Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 ● Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-11-1163-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: WAL MART ASSOCIATES INC Box #: 53	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Requestor's Position Summary as noted on the Table of Disputed Services: "Patient Pd. Cash emergency status Pre-Op."

Principle Documentation:

1. DWC 60 package
2. Receipt
3. Amount in Dispute: $$300.00

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPLE DOCUMENTATION

Respondent's Position Summary: "Please note that the self insured and the injured employee have come to an agreement. Se the attached DWC-24, which indicates the parties agree the claimant will be reimbursed at $150.00 for the out-of-pocket expenses and the Medical Fee Dispute will be withdrawn. The claimant agreed verbally and signed DWC-24, will be forthcoming to the Medical Fee Dispute Resolution Department."

Principle Documentation:

1. DWC 60 package

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
10/08/10	EOBs not submitted	Out-of-Pocket Expenses Echocardiogram (CPT Code 93306) and Carotid & Vertebral Duplex (CPT Code 93880	$300.00	$0.00
Total Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

1. The Arkansas Claims Managements agent has submitted a signed DWC-24 that shows the claimant has agreed to be reimbursed in the amount of $150.00 as payment in full for the services rendered on 10/08/10. The agent also submitted a check register showing payment with check number 2907790, issued on 01/10/11in the amount of $150.00 paid to the claimant.

2. **Conclusion**

Therefore, in accordance with 28 Tex. Admin. Code Section §133.307(e)(3)(A) the Division has determined that this dispute no longer exists. As a result, the amount ordered is $0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Sec. §413.011(a-d), §413.031 and §413.0311
28 TAC Section §133.307

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code, Sec. §413.031, the Division has determined that the Requestor is entitled to $0.00 reimbursement.

		01/21/11
Authorized Signature	Auditor III Medical Fee Dispute Resolution	Date

PART VIII: : YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.